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In the Supreme Court

of the United States

OCTOBER TERM, 1974

ABBOTT LABORATORIES, an Illinois corporation; AMERICAN HOME PRODUCTS CORPORATION, a Delaware corporation; BRISTOL-MYERS COMPANY, a Delaware corporation; CARTER-WALLACE, INC., a Delaware corporation; ELI LILLY AND COMPANY, an Indiana corporation; ENDO LABORATORIES, INC., a Delaware corporation; ORTHO PHARMACEUTICAL CORPORATION, a New Jersey corporation; SQUIBB CORPORATION, a Delaware corporation; E. R. SQUIBB & SONS, INC., a Delaware corporation; A. H. ROBINS COMPANY, INC., a Virginia corporation; WILLIAM H. RORER, INC., a Pennsylvania corporation; and WARNER-LAMBERT PHARMACEUTICAL COMPANY, a Delaware corporation,

Petitioners,

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

PETITIONERS' BRIEF

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PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., an Oregon non-profit corporation, on behalf of its assignors,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITIONERS' BRIEF

OPINIONS BELOW

The oral opinion of the district court of May 25, 1973 granting petitioners' motion for partial summary judgment is not reported. The opinion of the Court of Appeals of December 26, 1974, vacating the judgment of the district court, is reported at 510 F.2d 486 and at 1974-2 Trade Cases ¶ 75,437.

JURISDICTION

The judgment of the Court of Appeals was entered on December 26, 1974. Petitioners filed a timely petition for rehearing and suggestion for rehearing in banc, which was denied on March 11, 1975. Petitioners filed a petition for certiorari on April 10, 1975, invoking the jurisdiction of this Court under 28 U.S.C. § 1254(1). The petition was granted on June 23, 1975.

STATUTES INVOLVED

1. Section 1 of the Robinson-Patman Act, 49 Stat. 1526, 15 U.S.C. § 13(a):

> "(a) It shall be unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality, where either or any of the purchases involved in such discrimination are in commerce, where such commodities are sold for use, consumption, or resale within the United States or any Territory thereof or the District of Columbia or any insular possession or other place under the jurisdiction of the United States, and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them. . . ."

2. The Nonprofit Institutions Act, 52 Stat. 446, 15 U.S.C. § 13c:

> "Nothing in sections 13 to 13b and 21a of this title, shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit."

QUESTION PRESENTED FOR REVIEW

The Nonprofit Institutions Act of 1938, 15 U.S.C. § 13c, exempts from the Robinson-Patman Act purchases of supplies by nonprofit hospitals "for their own use." The Court of Appeals held, as a matter of law, that the exemption extends only to purchases of pharmaceutical products which are dispensed to hospital inpatients and to emergency room patients, and that purchases of drugs by hospitals for all other purposes are outside the scope of the exemption.

The question presented for review is whether drugs are purchased by nonprofit hospitals "for their own use" only if they are thereafter dispensed to hospital inpatients and to emergency room patients, and not if they are dispensed to patients treated as outpatients, to inpatients as take-home drugs when they leave the hospital, or to staff and employees of the hospital.

STATEMENT OF THE CASE

1. Proceedings in the Lower Courts.

Petitioners are twelve manufacturers of pharma-

ceutical products. Respondent filed this action for treble damages and injunctive relief as the assignee of the claims of some sixty commercial pharmacies doing business in metropolitan Portland, Oregon, charging petitioners with violations of the antitrust laws. The jurisdiction of the district court was invoked under 15 U.S.C. §§ 15 and 26 (R. 1-19).

Respondent's amended complaint stated five claims, only the second of which is before this Court (R. 52-69).[1] In its second claim, respondent alleged that in selling drugs petitioners discriminate between nonprofit hospitals and commercial pharmacies, including respondent's assignors (R. 61). As one affirmative defense, petitioners in their respective answers pleaded that their sales of drugs to nonprofit hospitals were exempt from the Robinson-Patman Act under the Nonprofit Institutions Act of 1938, 15 U.S.C. § 13c (R. 182-263).

The parties engaged in extensive discovery of the nonprofit status and drug dispensing practices of Portland area institutions that operate as nonprofit hospitals. Petitioners then filed a motion for summary judgment on the second claim under Rule 56 F.R. Civ. P. (R. 384-385).

On May 25, 1973 the district court granted the motion, concluding that there was no genuine issue as

[1] Charges of discrimination in sales to city, county and state governments and to the federal government were dismissed for failure to state a claim (R. 868-869). A charge of discrimination in sales to proprietary hospitals and commercial entities is pending, and discovery is proceeding. A fifth claim, charging that these alleged discriminations are the product of a conspiracy, also remains pending.

to any material fact with respect either to the nonprofit status of the hospitals or to their use of drugs. The court held that all of the hospitals were nonprofit institutions and that their drug purchases were exempt from the Robinson-Patman Act as a matter of law under the Nonprofit Institutions Act of 1938 (Tr. 5/25/73 at pp. 88 to 99).

In its oral opinion, the district court first considered the dispensing of drugs to inpatients, noting that "the vast majority of the drugs" are purchased for that purpose and that respondent conceded that such purchases are for the hospitals' "own use." It held that such purchases are clearly within the exemption of Section 13c (Tr. 92-93).

With respect to the hospitals' other uses of drugs, the district court held that drugs dispensed to outpatients are also purchased for the hospitals' "own use," and that this conclusion is not affected by the fact that many hospitals are expanding their outpatient services to the community.

> "I do not believe that it was the Congressional purpose to render inapplicable the statute merely because there was a change in the distribution of health care wherein the degree of out-patient treatment increased over the years since the 30's when this statute was passed" (Tr. 93).

The district court also held that take-home drugs "are indeed for the use of the hospital and thus qualify for the exemption", and that dispensing drugs to employees and staff physicians for personal and

family use also "may fairly be said to be for the use of the hospital" (Tr. 93-94).

On these grounds, the court entered summary judgment for petitioners on respondent's second claim (R. 868-869).

The district court certified its judgment order under 28 U.S.C. § 1292(b), and respondent appealed to the Court of Appeals for the Ninth Circuit. On December 26, 1974 the Court of Appeals rendered its opinion vacating the judgment (Petition A1 to A9).[2]

It affirmed the district court's decision that the thirteen hospitals (referred to hereafter as "the hospitals") which render services to the public generally are nonprofit institutions and qualify for the exemption under Section 13c (Pet. A3 to A4).[3] It also agreed with the district court that "by far the greater part of hospital distribution" is for inpatient and emergency treatment and is within the scope of the Section 13c exemption (Pet. A6).

However, the Court of Appeals disagreed with the district court over the proper interpretation of Section 13c as applied to other drug dispensing by the

[2] The appendix has been deferred by stipulation, Rule 34 (4), and references to the opinion of the Court of Appeals will be to appropriate pages of the petition for certiorari, where it is reproduced.

[3] The Court of Appeals found that there were disputed issues of fact relating to Bess Kaiser Hospital, which is affiliated with a health maintenance organization that principally serves its own members, and remanded those issues to the district court for further proceedings (Pet. A4 to A5). No party has sought review of the court's disposition of that aspect of the case.

hospitals. It held, as a matter of law, that a hospital's "own use" of drugs under the statute includes only drugs administered to inpatients and to patients in the emergency room. Thus, in the court's view, drugs dispensed to registered hospital patients who are treated as outpatients, to inpatients as take-home drugs at the time of their discharge, and to hospital employees and staff physicians for personal and family consumption are not purchased for the hospital's "own use" and are not exempt from the Robinson-Patman Act (Pet. A6 to A7).[4]

The Court of Appeals summarized its views as follows:

> "We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.' Hospital use under § 13c, in our judgment, must be limited to use made by the hospital in dispensing drugs for hospital or clinic treatment of in-patients or emergency patients. The purpose for which these supplies are purchased — the use to which they are to be put — is their consumption. Section 13c can apply here only to cases in which a hospital can be said to be the consumer. It cannot apply to cases of resale by the hospital to a private consumer." (Pet. A7).

[4] Three other kinds of hospital drug dispensing referred to by the Court of Appeals (Pet. A5 to A6) do not occur in significant amounts: To physicians for dispensing in the course of their private practices, to discharged patients as refills of take-home prescriptions, and to walk-in customers.

The court remanded the case for further proceedings (Pet. A9). Petitioners filed a timely petition for rehearing and suggestion for rehearing in banc, which was denied on March 11, 1975 (Pet. A18 to A19). On April 10, 1975 petitioners filed a petition for certiorari, which was granted on June 23, 1975.

2. Statement of the Facts.

A.

The facts with respect to the hospitals' distribution of drugs,[5] viewing the evidence favorably to respondent,[6] are summarized in the opinion of the Court of Appeals. The record on which the opinion is based shows the following:

Each of the hospitals has a pharmacy through which it dispenses drugs, primarily to inpatients. The pharmacy is an integral department of the hospital, and its operation produces revenues in excess of costs which belong to the hospital and are used to support

[5] The hospitals are:
Dwyer Memorial Hospital & Medical Center
Emanuel Hospital
Good Samaritan Hospital & Medical Center
Gresham Community Hospital
Holladay Park Hospital
Physicians and Surgeons Hospital
Portland Adventist Hospital
Portland Osteopathic Hospital
Providence Hospital
St. Vincent Hospital & Medical Center
Tuality Community Hospital
Willamette Falls Community Hospital
Willamette Methodist Convalescent Center (Pet. A2, n. 3).

[6] See *Arnett* v. *Kennedy* (1974) 416 U.S. 134, 139-140.

departments and activities which do not generate sufficient revenue to maintain themselves (see Table 1 at p. 31 below).[7]

Persons receiving hospital services are broadly classified as inpatients and outpatients, which are described in the Department of Health, Education and Welfare Hospital Insurance Manual and in publications of American Hospital Association.[8] An inpatient, according to HEW, is anyone who is admitted for overnight bed occupancy to receive hospital services. An outpatient is anyone who is registered on the hospital records as an outpatient and "receives services (rather than supplies alone) from hospital personnel." A "day patient," i.e., an individual who receives hospital services during the day but is not expected to remain at night, is an "outpatient." American Hospital Association defines an inpatient as one "who is given lodging while receiving physician, dentist or allied services in the hospital"; an outpatient is a pa-

[7] In Exhibit 1 to this brief are tables of references to the deposition testimony of more than 30 hospital witnesses which describe the pharmacy policies and operations of the hospitals.

[8] Hospital witnesses agreed with these definitions: Emmanuel (Hanson Dep. 7-10, H Ex. 2); Good Samaritan (Kaeser Dep. 7, Exs. 3, 4); Providence (Wong Dep. 26-27, Exs. 9, 10); St. Vincent (McConnell Dep. 20, Mc Ex. 2; Camosso Dep. 36); Adventist (Shupe Dep. 9-10, Exs. 4, 5, 6); Portland Osteopathic (Matlick Dep. 19-20); Physicians and Surgeons (Bleckinger Dep. 10-11, Ex. 7); Tuality Community (Hastings Dep. 9); Willamette Methodist (Slick Dep. 12); Holladay Park (Zeasas Dep. 26-27, Exs. 14, 15); Dwyer Memorial (Lindley Dep. 5; Haas Dep. 13-14); Willamette Falls (Hollowell Dep. 8-9).

tient "who is not lodged in a hospital" while receiving such services.[9]

In the most recent periods for which hospitals could supply data, inpatient drug sales accounted for about 90 percent of all pharmacy revenues.[10]

B.

Three kinds of drug dispensing are principally in issue:

1. Take-home drugs.

These are drugs that are dispensed by the hospital on the instructions of treating doctors to be taken home by patients when they are discharged. Amounts are determined in each case by the treating doctor and are normally limited to a short-term supply (see Table 2 at p. 32 below).

[9] The record shows one variation: At Emanuel Hospital, persons receiving "day surgery" are regarded as inpatients, while HEW regards this as an outpatient service (Hanson Dep. 10).

[10] At the request of the district court (Tr. 1/8/73 at pp. 11, 16, 20), the parties prepared charts, which are in the record, summarizing hospital drug distribution as shown by the depositions of hospital witnesses and by hospital records (Supp. Rec. 11/14/73 at p. 2). The charts were closely similar, and petitioners, for purposes of their motion for summary judgment, accepted respondent's chart as an accurate summary of the record with respect to the hospitals (Tr. 5/25/73 at pp. 16 to 17).

2. Drugs dispensed to registered outpatients.

Six of the hospitals have outpatient clinics[11] where persons registered as hospital patients are treated on an ambulatory basis. Prescriptions written for those patients are routinely filled at the hospital pharmacies. Many outpatient clinics primarily serve the poor and are operated at a loss; in addition, they are an important part of the hospital's educational program, providing a teaching resource for resident and intern doctors and for nurses (see Table 3 at p. 33 below). New hospital outpatient services such as maternal and infant care and family planning are also being developed (Hanson Dep. 21-25). At Willamette Methodist, persons living at a nearby retirement home are treated as outpatients at its convalescent center (Slick Dep. 11-12).

3. Drugs dispensed to employees, students and staff doctors.

All of the hospitals permit their employees (nurses, technicians, etc.), students, and staff physicians to purchase drugs at the hospital pharmacy for their personal use and for the use of members of their immediate families,[12] as a fringe benefit of their hos-

[11] Emanuel (Hanson Dep. 21-26); St. Vincent (Camosso Dep. 14, 39-40); Good Samaritan (Kaeser Dep. 33, 45, 53); Providence (Wong Dep. 8 and Johnston Dep. 39-40); Holladay Park (Zeasas Dep. 34-35); and Willamette Methodist (Slick Dep. 23-24).

[12] Some of the hospitals treat volunteer workers as employees for this purpose, e.g., Emanuel (Fawkes Dep. II, 31-32); Good Samaritan (Kaeser Dep. 35, 43, 46); Providence (Wong Dep. 21, 31-32); Holladay Park (Zeasas Dep. 20-21).

pital employment (Camosso Dep. 8, 12, 13). This "pharmacy privilege" is described in literature handed to newly-hired employees and is provided for in the collective bargaining agreements of some of the hospitals (see Table 4 at p. 34 below).

C.

The hospitals do not engage in commercial redistribution of drugs that they purchase. Occasional sales are made to walk-in customers, that is, persons having no connection with the hospital, but their volume amounts to less than one-half of one percent of drug sales. The hospitals do not seek or advertise for walk-in business, and sales of this type, when they do occur, often take place during hours when commercial pharmacies are closed and the purchaser has an immediate need for the medication (see Table 5 at p. 35 below).[13]

None of the hospitals supplies drugs to other markets. None purchases drugs for, or distributes them to, other hospitals or pharmacies, except on occasions when a drug is needed because of an emergency (see Table 6 at p. 36 below).

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[13] Dwyer Memorial Hospital will handle walk-in business "on a limited basis," usually for elderly persons residing in the immediate area, or on referrals from community pharmacies for specialty items (Haas Dep. 8-9, 19). Willamette Methodist Hospital will serve retired persons living at Willamette View Manor, which is nearby, but will not serve other walk-ins (Slick Dep. 11-13, 25; Renfrow Dep. 13-14, 23). Both of these hospitals are small and are located in outlying suburban neighborhoods.

SUMMARY OF ARGUMENT

The Nonprofit Institutions Act of 1938 was enacted so that hospitals and other nonprofit institutions that serve important public interests could lawfully purchase their supplies as inexpensively as possible. As applied to hospitals, the Act is not limited to purchases of drugs that are dispensed to bed patients and to emergency patients. Hospital use of drugs includes other critically important services to patients that the court recognized are "proper" hospital functions but declined to include within the exemption of the Act. The Court of Appeals erred in holding that drugs are not purchased for the hospital's "own use" if they are thereafter dispensed as take-home drugs, or to hospital outpatients, or as a "pharmacy privilege" to employees and staff doctors.

1. The legislative history of Section 13c shows that Congress intended to enact a broad exemption to the Robinson-Patman Act based on the public and nonprofit character of the beneficiary institutions. The exemption should not be limited to purchases for "noncompetitive uses" that cannot be supplied by regular commercial channels and would not violate the Robinson-Patman Act in any case.

2. The Section 13c exemption extends to all purchases of supplies for use in carrying on medical care programs of nonprofit hospitals. In *Logan Lanes, Inc.* v. *Brunswick Corporation*, (9th Cir. 1967) 378 F.2d 212, cert. den. (1967) 389 U.S. 898 the court correctly held that the exemption applies to all purchases of

supplies to meet the institution's needs, however they are disposed of and whether or not the public has access to them or the institution earns net revenues from their use.

3. The Section 13c exemption should be construed to follow modifications of hospital programs that are responsive to public needs and which expand outpatient and other services to persons who are not bedridden. Drugs are as important a component of outpatient care as of inpatient care, and dispensing drugs to outpatients from supplies maintained by the hospital and available for that purpose is part of its responsibility for their medical care.

4. Filling take-home prescriptions is a critical part of the hospital's responsibility to its bed patients, many of whom are physically unable to secure drugs from commercial pharmacies when they are discharged.

5. Filling prescriptions for employees and staff doctors is an integral and important part of the hospital's working relationship with the people whose services make its successful operation possible.

6. The decision of the Court of Appeals will have serious adverse consequences for hospitals and their patients, including the prospect of higher costs for a significant part of hospital drug purchases, and may cause them to limit their services to the public. Segregating drug supplies or use would be a clumsy and impractical accommodation to the Court of Appeals' opinion and would increase the cost of the pharmacy operation to hospital users.

Hospital suppliers also face serious problems under the decision of the Court of Appeals. If a supplier wishes to extend discounts under Section 13c, it must police the hospitals' subsequent use of each item of drugs that they purchase and sustain the risk of retroactive liability for any failure to do so. Placing restrictions on the hospitals' use of the drugs would also expose it to the risk of liability for violating the Sherman Act. *United States* v. *Arnold, Schwinn & Co.*, (1967) 388 U.S. 365.

ARGUMENT

Introduction

The Nonprofit Institutions Act provides:

> "Nothing in sections 13 to 13b and 21a of this title shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit." 15 U.S.C. § 13c.

The question before the Court is defined by the statute — whether nonprofit hospitals purchase for their "own use" drugs which are dispensed in admittedly legitimate hospital functions other than providing bed care and emergency care. These additional hospital functions, which the Court of Appeals excluded from the statutory exemption as a matter of law,

include dispensing drugs to inpatients at the time of their discharge, to registered hospital outpatients, and to employees and staff doctors for personal and family use.

Thus, the dispute is not between the pharmacy profession and drug manufacturers. Rather, it is between commercial pharmacists on the one hand and nonprofit hospitals (and their pharmacists) on the other. It arises because the dispensing of drugs is a normal component of hospital treatment and service,[14] which are diverse and extend beyond the hospital ward. The hospital's compelling interest in maintaining supplies of drugs that are available to those whom it serves extends to all of them, including the bed patient who is being released and the ambulatory outpatient. Its functions and its responsibilities are not limited to the bedridden. The Court of Appeals applied a concept of the nature and functions of hospitals that is inconsistent with the facts of hospital operations and is contrary to the public interest.

1. The Nonprofit Institutions Act of 1938 was enacted to permit hospitals and other nonprofit institutions to obtain their needed supplies as inexpensively as possible. The decision of the Court of Appeals is inconsistent with that legislative purpose.

The legislative history of the Nonprofit Institutions Act of 1938 is inconsistent with the view of the Court of Appeals that the exemption it provides

[14] See *Hospital Building Co.* v. *Trustees of Rex Hospital*, (4th Cir. 1975) 511 F.2d 678, 683, pet. cert. pdg.

from the Robinson-Patman Act is limited by narrow concepts of institutional "use," so as to apply in this case only to drugs dispensed to bed patients and in the emergency room. On the contrary, the exemption statute was written to assist a wide range of nonprofit institutions to operate at the lowest possible cost in the public interest, and should be interpreted to achieve that legislative purpose.

The 1938 reports of the Judiciary Committee of the House and Senate recommending passage of HR 8148[15] concluded that it was not in the public interest to apply the Robinson-Patman Act to nonprofit institutions in whose operation the public has a substantial stake. It was the character of such institutions, not particular features of their programs, that made it inappropriate to apply the price discrimination act to their purchases.

Thus, in House Report 2161, 75th Cong., 3d Sess., April 19, 1938 the House Judiciary Committee recommended adoption of the bill to make certain that price reductions "to eleemosynary institutions, because of the character of the institution, do not fall under the ban of the act." Similarly, the report of the Senate Judiciary Committee stated that the legislative purpose of the Robinson-Patman Act in prohibiting price discrimination between purchasers "does not seem to apply as to eleemosynary institutions as they are not operated for profit. The act does forbid such favors

[15] The texts of the Committee reports are found at pp. 37-41 below.

as might now be granted by sellers to such institutions." Senate Report 1769, 75th Cong., 3d Sess., April 20, 1938.

The supporting letter of the President of the Hospital Bureau of Standards and Supplies, attached to both reports, emphasized the consequences of increasing the cost of operations of institutions that serve the public by caring for the "needy sick."[16] The record in this case shows that a major purpose of maintaining outpatient clinics for ambulatory patients at hospitals is to care for the needy sick; yet the Court of Appeals held, as a matter of law, that dispensing drugs to such registered outpatients in the course of their hospital care is not within the scope of the exemption. In fact, medical services to outpatients are as much the proper business of a modern hospital as services to inpatients, and the public interest in an economical hospital operation extends to both.

The Senate report also shows that the exemption was intended to reach and protect purchases of supplies which would otherwise violate the Robinson-Patman Act, i.e., it was the purpose of the 1938 statute to authorize price discriminations between customers, who were the primary beneficiaries of the 1936

[16] However, Congress refused to limit the exemption to institutions which operate at a loss or are subsidized by the public. As originally drafted, HR 8148 included only ". . . institutions not operated for profit *and supported in whole or in part by public subscriptions.*" The italicized language was deleted by the House Judiciary Committee. 83 Cong. Rec. 6065 (1938).

amendments to the Clayton Act,[17] when the favored customer was a qualified nonprofit institution. However, purchases of drugs held to be exempt by the Court of Appeals would not violate the Robinson-Patman Act in any case, because the court limited the exemption to purchases for uses which retailers cannot supply and which therefore can have no competitive impact on retailers.[18]

The legislative purpose to exempt the hospitals' purchases of supplies from the Robinson-Patman Act would be frustrated by limiting the statute to narrowly-defined institutional uses that do not reflect the range of their services to the public and cannot be supplied by other purchasers, such as respondent's assignors.

2. The Nonprofit Institutions Act of 1938 applies to all purchases of drug supplies by hospitals for dispensing in the course of providing their services to the community.

The Nonprofit Institutions Act of 1938, in general terms, exempts from the Robinson-Patman Act all purchases of supplies for the use of the purchasing institution. It should be construed to re-

[17] See generally Rowe, Price Discrimination Under the Robinson-Patman Act, (1962) pp. 3-23; Patman, Complete Guide to the Robinson-Patman Act, (1963 ed.) pp. 7-10.

[18] See *Ag-Chem Equipment Co., Inc.* v. *Hahn, Inc.*, (8th Cir. 1973) 480 F.2d 482, 490-491; *Sano Petroleum Corp.* v. *American Oil Co.*, (E.D. N.Y. 1960) 187 F. Supp. 345, 357; *Secatore's Inc.* v. *Esso Standard Oil*, (D. Mass. 1959) 171 F. Supp. 665; Rowe, Price Discrimination Under the Robinson-Patman Act, supra, (1962) p. 176; 1 Callman, The Law of Unfair Competition 969 (3d ed. 1967) § 28.1(b)(7).

flect all of the integrated operations of hospitals which purchase their supplies under its protection, not in narrow terms that will inhibit their programs of medical care or modifications of existing services in ways beneficial to the public.

This view is consistent with the analysis of the Act which was the basis of the same Court of Appeals' prior decision in *Logan Lanes, Inc.* v. *Brunswick Corporation*, supra, (9th Cir. 1967) 378 F.2d 212, cert. den. (1967) 389 U.S. 898, the only previous case that has closely considered Section 13c.[19] In *Logan Lanes*, the proprietor of a commercial bowling establishment sought to recover treble damages from a manufacturer of bowling alleys and equipment, charging that the defendant had sold its products to the state of Utah at discriminatory prices for installation and use in the student union of one of its universities, and that the facility was used by the public in competition with plaintiff's business.

The Court of Appeals affirmed a summary judgment in favor of defendant. It held, first, that it did not matter if public use of the student union alleys was profitable to the university, because all net rev-

[19] The Court of Appeals cited *Students Book Company* v. *Washington Law Book Co.*, (D.C. Cir. 1955) 232 F.2d 49, 50-51, n. 5, cert. den. (1956) 350 U.S. 988, in which there is a footnote reference to the Act in an opinion announcing, but dissenting from the panel's decision (Pet. A7 to A8). The footnote states that the book purchases in question were not made by the universities at all, but by self-sustaining campus bookstores for resale; consequently, they were not purchases by the universities for their "own use." See also Anno: 3 A.L.R. Fed. 996 (1970).

enues were devoted to university purposes. 378 F.2d at 216. See also *Community Blood Bank of Kansas City Area, Inc.* v. *FTC*, (8th Cir. 1969) 405 F.2d 1011, 1019-1020. Second, the court held that the exemption applies to anything purchased for the primary purpose of fulfilling the needs of the institution, "whether it is consumed or otherwise disposed of", and that the exact amount of public use of such purchases, even if substantial, is not material. 378 F.2d at 216-217.[20]

Thus, the *Logan Lanes* court did not pass judgment on the university's decision to provide bowling alleys for its students and faculty or consider if such facilities are relevant to a program of higher education. Instead, it recognized the congressional purpose to allow these institutions "to operate as inexpensively as possible," which was incompatible with a narrow view of the statute. 378 F.2d at 216.

The court's analysis of Section 13c in *Logan Lanes* is in sharp contrast with the decision of the same court in this case. The transactions in which drugs are dispensed by hospital pharmacies are the same in all cases — all hospital drugs are "sold," whether to

[20] The Court of Appeals thought that *Logan Lanes* was inapplicable to this case, because it concerned purchases of capital equipment as well as of supplies, and that capital items cannot be segregated (Pet. A8 to A9). This distinction is not supportable. The problem, if there is one, lies in permitting public access to that which has been purchased at favorable prices. In practical terms, it is as simple to require the identification of customers of an entertainment facility as customers of a pharmacy; indeed, in *Logan Lanes* this is what plaintiff contended the university should have done.

bed patients or to outpatients or discharged patients, or to staff for personal and family use. The distinctions suggested by the Court of Appeals between "dispensing," "providing," and "selling" drugs to various categories of customers (Pet. A5 to A6) are without substance and are of no aid in interpreting the statute.

The proposition that drugs are "consumed" by the hospital if the patient is in bed, but are "consumed" by the patient if he receives treatment at the hospital and takes the drugs home, is equally insubstantial (Pet. A7). Drugs are "consumed" by people, whether in or out of bed, not by institutions, and the attempt of the Court of Appeals to equate "consumption" and "use" leads nowhere. Neither of these verbal propositions is a sustainable analysis of the Act.

3. The Nonprofit Institutions Act of 1938 should be construed to include modifications of hospital programs that provide outpatient and other medical services in response to public needs.

One hundred years ago, the principal function of most hospitals was to care for the poor. Today, however, major advances in medical science, technology and equipment have imposed on hospitals responsibilities to the community at large, rich as well as poor. To meet those responsibilities, these institutions have become larger and their services more diverse.[21]

[21] See *Eastern Kentucky Welfare Rights Org.* v. *Simon*, (D.C. Cir. 1974) 506 F.2d 1278, cert. granted May 19, 1975, in which the court noted that hospitals have ceased to be caretakers of the sick poor, and have become "the primary community health facility for both rich and poor." This process has occurred in the face of soaring costs, as "constant modernization of equipment and facilities is necessitated by the advances in medical science and technology." 506 F.2d at 1288.

This has not been a sudden development, at least as applied to hospital functions that are now in controversy. In 1938, as today, hospitals dispensed drugs to patients at the time of their discharge and provided outpatient medical services.[22] The hospital drug uses involved in this case are not new.

It is clear, however, that changes in the delivery of hospital services have occurred since the Second World War and will continue to occur. The modern nonprofit hospital is no longer a facility that serves only the bedridden, just as it formerly ceased to be one dedicated only to serving the poor; under modern conditions, hospitals are becoming medical centers

[22] The first outpatient clinic in this country was established to serve the poor by the Pennsylvania Hospital of Philadelphia, the nation's oldest hospital, in 1752. By 1916 there were 495 outpatient departments of hospitals engaged in treating general diseases, and their development as teaching facilities and in treatment of the poor has been consistent and substantial, both before and since the Second World War. See generally Sussman, Caplan, Haug and Stern, The Walking Patient, Western Reserve University, 1967, at pp. 2-7; Better Hospital Care for the Ambulant Patient, Hospital Association of Pennsylvania, 1946, at p. 2; Davis and Warner, Dispensaries, MacMillan, 1918, at p. 36; Merrill, "Hospital Pharmacy and Out-Patient Department," Hospitals, June 1941, at p. 33. Dispensing drugs was an established service of outpatient clinics in 1918. Davis and Warner, *op. cit.* at pp. 74, 92-93, 187-189.

for the communities which they serve.[23] Costly equipment and technologies available only in hospitals are widely used in expanded services for diagnosis and care of the public, and it has become necessary to deliver hospital services as efficiently and as cheaply as possible.

As a result, there have been changes in the various services that are conventional parts of a hospital's program. A major one is that much diagnosis and therapy, including surgery, which formerly required bed care, is now widely performed on an outpatient basis which is beneficial to the patient, extends the use of available capital, and reduces costs. There is increasing emphasis on ambulatory services for outpatients which are provided by the hospital at its principal institution and at detached facilities.[24]

These modifications of traditional hospital practices are inevitably reflected, not only in purchases of equipment and materials to build facilities for outpatient services, but in purchases of supplies, including drugs that are dispensed to outpatients in the course of their treatment.[25]

[23] This evolution in the functions and services of hospitals is described in a paper presented in November 1970 at the dedication conference of the Purdue University School of Pharmacy and Pharmacal Science and reprinted in 28 American Journal of Hospital Pharmacy 240 (1971) and in HEW Publication DHEW Pub. No. (HMS) 73-3001. The authors are Donald C. Brodie, of the University of California, and Mrs. Joe B. Graber, who were, respectively, the Director and the Special Assistant to the Director of the drug-related studies program of HEW. Portions of the study are reproduced below at pp. 42-43. See also John H. Knowles, The Hospital, Scientific American, September 1973, pp. 128, 136.

[24] See generally, Sussman, Caplan, Haug and Stern, The Walking Patient, supra, at pp. 4-7.

The application of Section 13c to drugs dispensed to these patients cannot depend on the capacity or willingness of commercial pharmacies to supply some part of them. This use is an integral part of the hospital care which the ambulatory patient receives from the institution; the controlling circumstance is that the drugs are dispensed to the patient by the hospital in connection with its services, whether he is sitting, standing or lying down, and wherever he may be when he consumes them.

Under the Act, hospital "use" extends to all dispensing of drugs that occurs in connection with the hospital's services, including its care of those who are not bedridden. The increased dispensing of drugs to ambulatory patients that has accompanied these trends in hospital services does not exceed the terms or intent of a statute which was intended to permit nonprofit hospitals to operate inexpensively in the public interest. The reference in the Act to a qualified institution's "own use" of supplies purchased at reduced prices is comprehensive; it is not a definition of "use," but merely describes the buyer's purpose in unrestricted and general terms. The statute must be construed to accommodate modifications of hospital programs that are the result of changing conditions.

[25] See Francke, Latiolais, Francke and Ho, Mirror to Hospital Pharmacy, American Society of Hospital Pharmacists, 1964, at pp. 67-68, 117-120.

4. Purchases of drugs dispensed in filling take-home prescriptions are within the Section 13c exemption.

The universal hospital practice of dispensing drugs to bed patients for use after leaving the institution is a necessary service of the hospital that provides continuity during the transition from hospital care to home care. Newly discharged hospital patients cannot be expected to patronize the corner drugstore, and the hospital can scarcely abandon them in the expectation that they will do so. In fact, many are not yet well enough and do not have the support of a family or others who might assist them to get drugs. The narrow construction given to Section 13c by the Court of Appeals, which considered only the place where the patient consumes the drug, ignores the practical and pressing needs of those who are discharged from hospital bed care.

For any purpose relevant to the statute, dispensing drugs to a bed patient who is going home is indistinguishable from dispensing the same drugs to the patient before he is discharged. Both are essential to the responsible rendering of hospital services, and purchases of drugs for such purposes are within the scope of the Act.

5. Purchases of drugs dispensed to employees and to medical staff under the pharmacy privilege are within the Section 13c exemption.

The pharmacy privilege that all of the hospitals extend to their employees, students and staff physi-

cians, often at a discount, is equally important in achieving the institution's purposes.

A hospital is an association of facilities and people who pursue a common undertaking, and the privilege of purchasing drugs at the hospital pharmacy is part of the working relationship between the institution and its employees and medical staff, a relationship which may also include a lunch room supplied with food purchased at reduced prices and other benefits that "compete" with nearby businesses. The privilege is a conventional "fringe benefit" that is not significantly different from a wide range of other in-house benefits that are characteristically afforded by profit and nonprofit institutions alike to promote job affiliation and performance.[26]

The "pharmacy privilege" is an established and important characteristic of nonprofit hospitals, and it constitutes the institutions' "own use" of drugs within the meaning of Section 13c.

6. The decision of the Court of Appeals establishes an unworkable standard for hospitals and their suppliers.

The decision of the Court of Appeals is an unfortunate distortion of Section 13c which adversely affects all nonprofit institutions which charge their constituency for supplies that are consumed in the course of educational, religious, medical or other programs. Present consideration, however, is limited to the

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[26] E.g., faculty and staff use of university bowling alleys that was considered in *Logan Lanes*, supra, 378 F.2d at 216.

parties to a hospital pharmacy transaction — the hospital, the drug purchaser and the supplier.

The Court of Appeals' decision impairs the operation of the statute, so as to threaten hospitals with increased costs and the public with reduced levels of service. There are at least two undesirable consequences of the decision: First, by sharply limiting the use of drugs purchased at favorable prices under Section 13c, the decision may increase direct institutional costs by requiring a significant portion of all hospital drugs to be purchased at regular trade prices. Second, the decision requires a segregation of drugs or accounting of their use that can be achieved only through the institution of clumsy and expensive dual supply or tracing systems to regulate and account for the use of drugs.[27]

The hospitals could, of course, give up lawful discounts on their drug purchases for inpatients and emergency patients, or they could cease to provide drugs for other "proper," but excluded, hospital functions — with no assurance that retail pharmacies would provide alternative supplies when and as they are needed. These choices can hardly be regarded as in the public interest.

Equally serious are the problems that the decision

[27] The Court of Appeals believed that drugs for "non-hospital" use "can readily be segregated" (Pet. A9), a view that is almost certainly incorrect. Hospitals can scarcely be expected to operate two pharmacies, one for inpatients and emergency room patients to whom the bulk of their drugs are dispensed, and another for all other drug dispensing. This would require separate purchasing, separate inventories, separate accounting, separate dispensing and separate pricing.

presents to those who supply drugs to nonprofit hospitals. Some suppliers have sought to prevent the commercial redistribution of drugs supplied to nonprofit hospitals at reduced prices by placing appropriate labels on the containers or by agreements restricting subsequent distribution (e.g., R. 871-873; Chartier Dep. Ex. 13-15). Others have not done so, which is understandable in light of the problems involved in controlling the disposition of merchandise in the hands of a purchaser. *United States* v. *Arnold, Schwinn & Co.*, supra, (1967) 388 U.S. 365, 379.

These devices, however, do not reach the case of a drug that disappears into a hospital inventory from which it may be dispensed in a "proper" hospital use, but one not recognized by the Court of Appeals. The result can be retroactive exposure to claims such as this, based on what the supplier's customer ultimately does with a small proportion of products that it purchases in substantial quantities.

The supplier's alternatives are also undesirable: It can, of course, abandon discounts to nonprofit hospitals, which is inconsistent with the statutory purpose to promote the inexpensive operation of these institutions; or it can try to police the hospital's use of the drugs, which presents it with the risk of liability under the Sherman Act.

The decision of the Court of Appeals is an unworkable limitation upon Section 13c that defeats the statutory purpose.

CONCLUSION

The judgment of the Court of Appeals should be reversed, and the district court's summary judgment construing Section 13c should be reinstated.

Respectfully submitted,

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August 7, 1975

EXHIBIT 1

TABLE 1. Use of net revenues from distribution of drugs for hospital purposes

Emanuel	Gustafson 4, 15-16; Steed 11.
St. Vincent	Camosso 18, 19.
Good Samaritan	Smith 10.
Providence	Johnston 5, 29, 38-39, 42-43; Wong 4-5.
Adventist	Ammon 28.
Osteopathic	Bremner 24-25; Matlick 4, 24-25, 26.
Gresham Comm.	Mack 5, 8, 13.
Phys. & Surgeons	Desrosiers 9-10.
Tuality	Hastings 5, 24-25.
Willam. Methodist	Slick 8-9, 22.
Holladay Park	Sperry 5, 14, 24; Zeasas 30.
Dwyer Memorial	Lindley 4, 15.
Willam. Falls	Hollowell 5, 10.

TABLE 2. Sales of take-home drugs and policy against refilling such prescriptions

Emanuel	Fawkes 20-21, 29, 37; Fawkes II 26-27, 41, 43; Gustafson 17-19, Ex. FX13.
St. Vincent	McConnell 23-26, 28-29; Camosso 7-8, 12-13.
Good Samaritan	Kaeser 8-10; Ex. KX7.
Providence	Johnston 17; Wong 25, 30-31.
Adventist	Ammon 23-24; Shupe 21, 27; Ex. SX2.[1]
Osteopathic	Bremner 11; Matlick 13-14; Ex. MX7, 9-13.
Gresham Comm.	Mack 6-7; Chartier 12-13; Ex. MX4, CK6.
Phys. & Surgeons	Desrosiers 6-7; Bleckinger 12; Ex. DX3.
Tuality	Eldien 11-12; Ex. HX7, 8, 15, 16.
Willam. Methodist	Renfrow 8-9, 11-12.[2]
Holladay Park	Sperry 7; Zeasas 15-16, 33.
Dwyer Memorial	Lindley 5-6; Haas 15-16.[3]
Willam. Falls	Hollowell 8; Ferrell 7, 14-16; Ex. HX11.

[1] Adventist will refill take-home prescriptions if the patient insists, but it discourages the practice. Adventist and Tuality prescription labels advise the patient to secure refills elsewhere.

[2] Willamette Methodist has no rule against refilling take-home prescriptions, but refills are rarely requested.

[3] Dwyer Memorial refills about one take-home prescription per day.

TABLE 3. Charitable and teaching functions of hospital outpatient clinics

Emanuel	Hanson 21-26.
St. Vincent	Camosso 14, 39-40.
Good Samaritan	Kaeser 33-34, 45.
Providence	Johnston 39-43; Wong 8, 32.
Willam. Methodist	Slick 23-24, 26-27.
Holladay Park	Sperry 20-21.[1]

[1] Holladay Park's outpatient clinics are primarily for providing post-discharge psychiatric treatment and occupational therapy.

TABLE 4. Sales to employees, students and staff physicians for personal and family use

Emanuel	Hanson 11-13, 25; Fawkes 5, 33; Gustafson 4-6; Steed 12; Ex. SX-4.
St. Vincent	McConnell 17-19, 22-23, 29-31; Camosso 28-31; Ex. CX10.
Good Samaritan	Kaeser 25-26, 31-32, 34, 38-40; Stocks 7, 11; Ex. KX15, ESX19.
Providence	Johnston 22-23; Wong 9-13, 22-23; Ex. JX19.
Adventist	Ammon 21-22;[1] Shupe 12-14, 28.
Osteopathic	Bremner 7; Matlick 10, 12, 19; Ex. MX5, 6.
Gresham Comm.	Mack 9, 11-12; Chartier 10-11; Ex. CX5.
Phys. & Surgeons	Bleckinger 6-8, 10-11; Desrosiers 7, 24; Ex. DX4.
Tuality	Hastings 10-11, 19-20; Eldien 5, 7; Ex. HX7, 10-12, EX13.
Willam. Methodist	Renfrow 10, 15-16; Slick 12, 18-19; Ex. SX5.
Holladay Park	Sperry 8; Zeasas 6, 17-19; Ex. SX3, 4.
Dwyer Memorial	Lindley 10-11; Haas 4-6, 20-21.
Willam. Falls	Hollowell 20-21; Ferrell 7-8, 9-10.

[1] Mr. Ammon testified that while there are no restrictions on purchases by employees and physicians, "it doesn't happen" that doctors fill their office needs at the Adventist hospital pharmacy.

TABLE 5. Lack of walk-in sales and policy against such sales

Emanuel	Hanson 12, 19; Fawkes 5-6, 10-12, 27, 29-30, 34; Fawkes II 30-31; Gustafson 7-8; Ex. FX13.
St. Vincent	McConnell 20-22, 46-47.
Good Samaritan	Kaeser 5-6, 10-11, 14-15, 39, 41-44; Ex. KX7.
Providence	Wong 21-22, 32-33.
Adventist	Shupe 24-25, cf. 31-32.
Osteopathic	Bremner 10-11, 25, 27; Matlick 10; Ex. BX14.
Gresham Comm.	Chartier 13, 15-16; Ex. CX6.
Phys. & Surgeons	Bleckinger 6-7; Desrosiers 16.
Tuality	Hastings 23.
Willam. Methodist	Renfrow 13-14.
Holladay Park	Sperry 10; Zeasas 6-7, 9-10, 19, 25-26, 32-33, 37.
Dwyer Memorial	Lindley 7-8; Haas 20; Ex. LX3.
Willam. Falls	Hollowell 19-20; Farrell 20.

TABLE 6. Policy prohibiting commercial redistribution of drugs

Emanuel	Hanson 13; Fawkes 15-17; Gustafson 5-6.
St. Vincent	McConnell 31; Camosso 14.
Good Samaritan	Kaeser 25, 50-51.
Providence	Johnston 18.
Adventist	Shupe 19-20.
Osteopathic	Bremner 20-22; Matlick 16-17.
Gresham Comm.	Chartier 16.
Phys. & Surgeons	Bleckinger 8-9; Desrosiers 13.
Tuality	Eldien 7.
Holladay Park	Zeasas 20.

EXHIBIT 2

NON-PROFIT INSTITUTIONS ACT REPORT
HOUSE OF REPRESENTATIVES

75TH CONGRESS
3rd Session

REPORT
No. 2161

EXEMPTION OF ELEEMOSYNARY INSTITUTIONS FROM THE ROBINSON-PATMAN ACT

April 19, 1938—Referred to the House Calendar and ordered to be printed

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MR. WALTER, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany H.R. 8148]

The Committee on the Judiciary, to whom was referred the bill H.R. 8148, to amend Public Law No. 692, Seventy-fourth Congress, second session, after consideration, report the same favorably to the House with an amendment with the recommendation that as so amended the bill do pass.

The committee amendment is as follows: "Strike out all of line 9."

The reported bill provides that the Robinson-Patman Act shall not apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.

The Robinson-Patman Act prohibits price discriminations between purchasers in interstate commerce, excepting differentials which make only due allowance for differences in the cost of manufacture, sale, or delivery resulting from the different methods or quantities in which such commodities are sold and delivered, where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition.

The committee does not feel that the wholesome purpose of the Robinson-Patman Act will be interfered wtih by the enactment of this bill to make certain that favors in price which are occasionally extended to eleemosynary institutions, because of the character of the institution, do not fall under the ban of the act.

In this connection there follows a self-explanatory communication from the president of the Hospital Bureau of Standards and Supplies, a nonprofit-making association of 200 voluntary hospitals located from Maine to Texas:

HOSPITAL BUREAU OF STANDARDS AND SUPPLIES,
New York, N. Y., December 18, 1937.

Hon H. W. SUMNERS,
United States House of Representatives
Washington, D. C.

MY DEAR CONGRESSMAN: The 2,700 voluntary nonprofit hospitals of the country spend over 150 mil-

lion dollars a year on foodstuffs and supplies for the care of the needy sick, who would otherwise be a burden on Federal, State, and municipal institutions.

Because of the charitable nature of their work many suppliers have hitherto allowed these institutions special prices on their purchases. This the Robinson-Patman Act now prohibits and as a consequence, hospital supply bills are increasing about 20 percent.

Most, if not all, of these institutions have for years operated at a deficit. If these deficits are to be increased by 30 million dollars a year, many hospitals may have to close their doors. The needy sick must be cared for and such a development would throw an almost impossible additional burden on the Federal, State, and municipal institutions.

We, therefore, respectfully request that you keep these facts in mind when the proposed amendment to the Robinson-Patman Act, exempting the eleemosynary institutions of the country, comes up for consideration of the Congress.

Sincerely yours,

JOHN H. HAYES, *President.*

75TH CONGRESS
3d Session

REPORT
No. 1769

SENATE

EXEMPTION OF ELEEMOSYNARY INSTITUTIONS FROM THE ROBINSON-PATMAN ACT

April 20 (calendar day, May 10), 1938
Ordered to be printed

MR. LOGAN, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany H.R. 8148]

The Committee on the Judiciary, to whom was referred the bill (H.R. 8148) to amend Public Law No. 692, Seventy-fourth Congress, second session, after consideration of the same, report favorably thereon to the Senate with the recommendation that it do pass.

The bill provides that the Robinson-Patman Act shall not apply to purchases of supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.

The purpose of the Robinson-Patman Act, to prohibit price discrimination between purchasers in interstate commerce where competition would thereby be lessened, does not seem to apply as to eleemosynary institutions as they are not operated for profit. The

act does forbid such favors as might now be granted by sellers to such institutions.

There follows a self-explanatory communication from the president of the Hospital Bureau of Standards and Supplies, a nonprofit association of hospitals, which letter was considered by the House.

• • •

EXHIBIT 3

From 28 American Journal of Hospital Pharmacy 240 (1971):

> Early in the 1960's the American Hospital Association approved a ". . . Statement on the Changing Hospital. . . ." The underlying concept in the Statement was that the hospital would become the repository for and custodian of a community's health resources — physical plant, technical manpower and equipment. Steps were taken in the past decade toward fulfilling this projection, in fact, some believe the hospital now is acquiring the qualities of the community health center.
>
> Numerous factors are contributing to this development. For example, the hospital is growing "centrally" because of increasing demands for its services, continual scientific specialization, and centralization of health resources. On the other hand, it is growing "peripherally" since it is being required to extend its services into the community because of the forces created by the physician shortage in selected areas and the need for lessening the high density of patients at the hospital. Thus, the community hospital is growing "inwardly" and "outwardly" simultaneously.
>
> As health centers, some community hospitals are providing a full spectrum of diagnostic and treatment services to the sick in addition to preventive and maintenance services to the apparent well. Community hospitals are assuming responsibility for selected social, environmental, rehabilitative and other health-related services. Some of

> this centralization of services has resulted from shifts taking place in the delivery of selected services from long-term to acute care hospitals. The sharing of services also has been a contributing factor.
>
> The emergence of the hospital as a community health center frequently represents a realignment of resources and management. Horizontal realignment is taking place through the establishment of satellite hospital systems, chains and mergers, while vertical realignment is seen where hospitals are providing for graded levels of care.
>
> The facilities for a system of comprehensive care may be clustered on a common campus, structured around the hospital. In other cases, services will be provided in an off-campus facility located at some other point in the community to facilitate access to primary care of some specialized service. Modern communication systems will permit continuous contact with the parent institution. Whatever arrangements develop in a given community, the hospital retains the central focus while its authority and that of its medical staff will extend to wherever in the community its services are needed.